

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Reg. Dist. No. **07173**

7184

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deal Island</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deal Island</b>			
c. LENGTH OF STAY IN 1b <b>lifetime</b>				d. STREET ADDRESS <b>Main Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>at home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marguerite Coster</b>				4. DATE OF DEATH Month Day Year <b>June 18 1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1892</b>		9. AGE (In years last birthday) yrs. <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Household</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Household</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Theodore White</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>George Coster</b>		Address <b>Deal Island, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>July 1955</b> 19___, to <b>June 18</b> 19 <b>61</b> , that I last saw the deceased alive on <b>6-13-61</b> 19___, and that death occurred at <b>8AM</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Everett C. Sutter</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>Dames Quarter, Maryland 6-19-61</b>			
PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/22/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. S. Webster</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 27 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO BE COMPLETED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be filled in by the attending physician and completely signed in by the funeral director. After this certificate has been signed by the attending physician and completely signed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VS. A15ME  
SM 7/59

## 07175

<b>1. PLACE OF DEATH</b> a. COUNTY <p align="center"><b>Somerset</b></p>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) b. STATE <p align="center"><b>Maryland</b></p>		c. COUNTY <p align="center"><b>Worcester</b></p>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <p align="center"><b>Crisfield</b></p>		c. LENGTH OF STAY IN lb <p align="center"><b>None</b></p>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <p align="center"><b>Pocomoke City</b></p>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <p align="center"><b>McCready Memorial Hospital</b></p>		d. STREET ADDRESS <p align="center"><b>518 Young Street</b></p>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <p align="center"><b>Lydia</b></p>		First Middle Last <p align="center"><b>Cropper</b></p>		<b>4. DATE OF DEATH</b> Month Day Year <p align="center"><b>June 30 1961</b></p>	
5. SEX <p align="center"><b>Female</b></p>		6. COLOR OR RACE <p align="center"><b>Negro</b></p>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <p align="center"><b>Apr. 24, 1896</b></p>		9. AGE (In years last birthday) yrs. <p align="center"><b>65</b></p>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <p align="center"><b>Hairdresser</b></p>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <p align="center"><b>Beauty Parlor</b></p>		<b>11. BIRTHPLACE</b> (State or foreign country) <p align="center"><b>Virginia</b></p>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <p align="center"><b>USA</b></p>		<b>13. FATHER'S NAME</b> <p align="center"><b>William Giller</b></p>		<b>14. MOTHER'S MAIDEN NAME</b> <p align="center"><b>Rachel Savage</b></p>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <p align="center"><b>No</b></p>		<b>16. SOCIAL SECURITY NO.</b> 		<b>17. INFORMANT</b> Address <p align="center"><b>Janie Thomas Atlantic, Va.</b></p>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <p align="center"><b>Coronary thrombosis.</b></p> DUE TO (Dead on arrival at McCready Hospital.) (b) Had previous history of treatment, coronary condition, by Dr. Norman Sartorius, Sr., Pocomoke City, Md.) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <p align="center">19</p>		<b>20d. INJURY OCCURRED</b> While al work <input type="checkbox"/> Not While al work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) 	
<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>DATE SIGNED</b> <p align="right"><b>7/1/61</b></p>					
<b>ACTUAL SIGNATURE</b> <i>C. G. Rawley</i> M.D. <b>EXAMINER'S NAME (Type)</b> <b>C. G. Rawley, M. D.</b> <b>324 Main St., Crisfield, Md.</b> Address (Street, city, town, or county)					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <p align="center"><b>Burial</b></p>		<b>22b. DATE THEREOF</b> <p align="center"><b>7-6-61</b></p>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <p align="center"><b>Jerusalem Cemetery</b></p>	
<b>22d. LOCATION (City, town, or country)</b> <p align="center"><b>Temperanceville</b></p>		<b>(State)</b> <p align="center"><b>Va.</b></p>			
<b>23. FUNERAL DIRECTOR</b> ADDRESS <p align="center"><b>Wharton &amp; Savage New Church, Va.</b></p>					
<b>24a. REC'D BY REGISTRAR</b> DATE JUL 7 '61 <b>24b. REGISTRAR'S SIGNATURE</b> Arthur L. Kline					

4. CHINA

30

2

五

**Abstract**

7186

## CERTIFICATE OF DEATH

Reg. Dist. No. 07175

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden</b> c. LENGTH OF STAY IN 1b <b>2 Years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden</b> <b>X</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <b>Leoden</b> First <b>Doane</b> Middle <b>Doane</b> Last			4. DATE OF DEATH Month <b>6</b> Day <b>18</b> Year <b>1961</b>										
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/12/1900</b>		9. AGE (In years last birthday) yrs. <b>61</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brick Layer Helper</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Cement Finishing</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>				
13. FATHER'S NAME <b>Samuel Henry Doane</b>						14. MOTHER'S MAIDEN NAME <b>Cynthia Wright</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>716-01-7153</b>			17. INFORMANT <b>Marion Cannon.</b> Address <b>Eden, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162.1</b> DUE TO <b>Left Lateral Carcinoma Toxic involving Sarcoma Left Shoulder.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchogenic Ca of Lungs;</b> DUE TO <b>Skin Involvement</b> (c) <b>4 months</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma</b>												INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>Feb. 13, 1961</b> to <b>June 9, 1961</b> that I last saw the deceased alive on <b>June 9, 1961</b> and that death occurred at <b>3:15 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED													
ACTUAL SIGNATURE <b>G. Herbert Sempley</b> M.D.			400 E. Church St. 6/23/61										
PHYSICIAN'S NAME (Type) <b>G. Herbert Sempley</b>			<b>Salisbury, Md.</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>6/24/61</b>			22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>			22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. James Jr.</b>						ADDRESS <b>Princess Anne, Md</b>			24a. REC'D BY REGISTRAR DATE <b>UN 2 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>		

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

WILLIAM BROWN

AGE 45

5

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7187

## CERTIFICATE OF DEATH

Reg. Dist. No. 07176

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne, X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Alice Elizabeth Jackson</u>				4. DATE OF DEATH <u>June 15 1961</u>			
5. SEX <u>Female</u>				6. COLOR OR RACE <u>Negro</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>June 1, 1904</u>			
9. AGE (In years last birthday) <u>57</u> yrs.				10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Norfolk, Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edmond Brockett</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Brockett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>158-34-3594</u>			
17. INFORMANT <u>Joseph Brockett</u>				Address <u>Princess Anne, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular</u> DUE TO (c) <u>Cardiac Decompensation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 yrs.</u> <u>2 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 1959</u> , to <u>June 15 1961</u> , that I last saw the deceased alive on <u>June 15 1961</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>20 Prince William St Princess Anne, Md.</u>			
ACTUAL SIGNATURE <u>B. Frank Giganti</u> M.D.				DATE SIGNED <u>6/16/61</u>			
PHYSICIAN'S NAME (Type) <u>B. FRANK GIGANTI M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 18, 1961</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope</u>				22d. LOCATION (City, town, or county) (State) <u>Greenwood Som. Co. Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>				ADDRESS <u>Marion Md.</u>			
24a. REC'D BY REGISTRAR <u>Arthur S. Finner</u>				24b. REGISTRAR'S SIGNATURE			
DATE <u>JUN 19 61</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF BIRTH

STATE OF MASSACHUSETTS

WILLIAM A. DULON



1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 07177

7188

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Fairmount</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Fairmount</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Rufus</b> Middle <b>J.</b> Last <b>Miles</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1869</b>
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John L. Miles</b>		14. MOTHER'S MAIDEN NAME <b>Malcah Muir Landing</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Margaret Miles</b>		Address <b>Upper Fairmount, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> <b>155.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>PRIMARY CARCINOMA LIVER</b> (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 MONS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>o.</b> p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/9</b> , 19 <b>58</b> , to <b>6/14</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>6/14</b> , 19 <b>61</b> , and that death occurred at <b>10 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Stanford Hamilton</b> M.D.		ADDRESS (Street, city or town, state) <b>212 MARKET ST.</b>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>C. STANFORD HAMILTON</b>		<b>POCOMOKE CITY, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-17-1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Miles Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Fairmount, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lewis R. Wilson</b>		ADDRESS <b>Princess Anne, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 20 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15, 1905		Baltimore, Md.	
Occupation		Cause of Death		Date of Death		Place of Death		Time of Death	
Teacher		Heart Disease		Jan 20, 1950		Home		10:00 AM	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Burial Officer		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Name of Hospital		Name of Burial Place		Name of Undertaker		Name of Funeral Home	
Jan 22, 1950		St. Mary's Hospital		Catholic Cemetery		John Doe & Co.		John Doe & Co.	

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

FOR STATE  
HEALTH DEPT

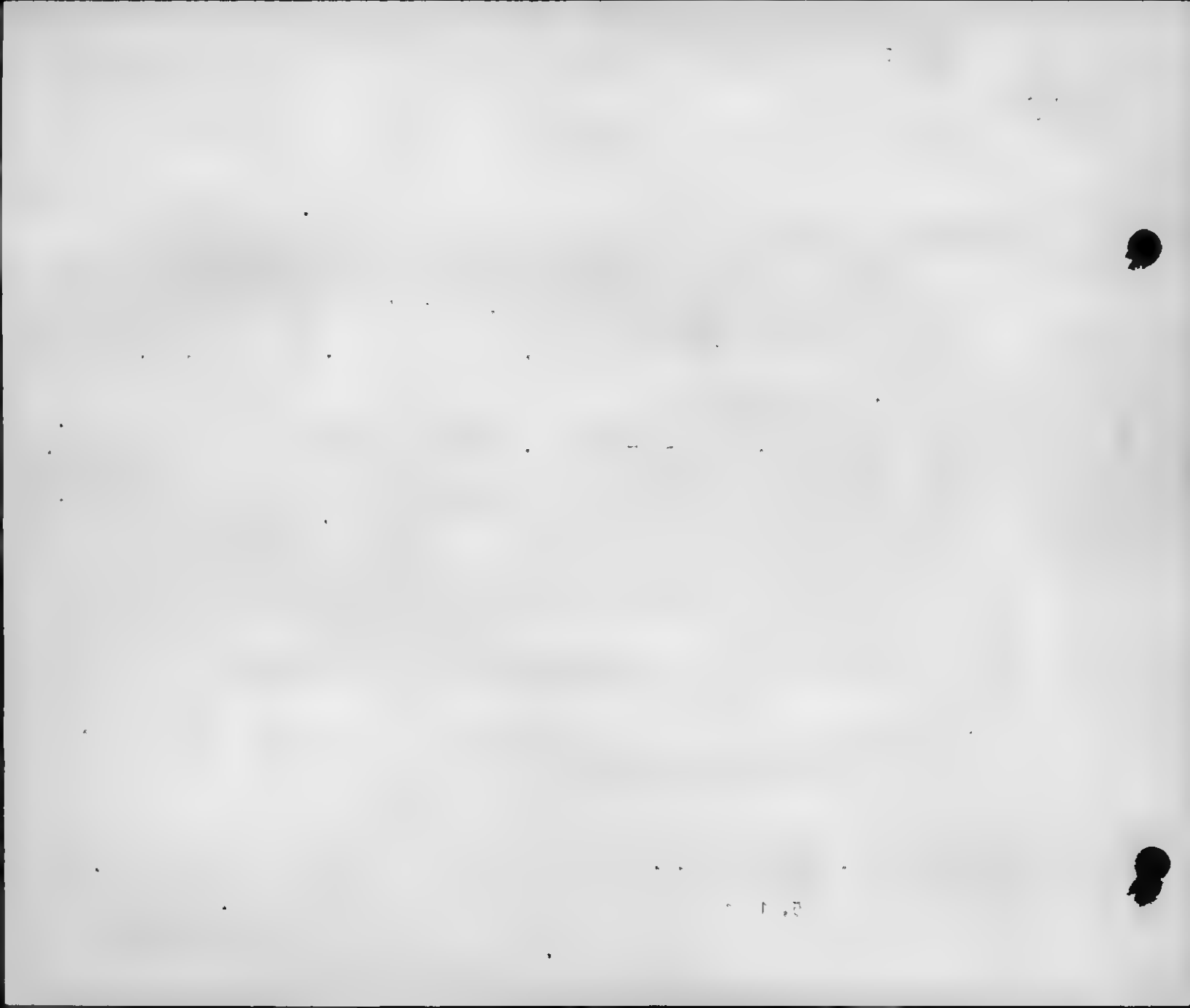
THIS STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary. Please execute the certificate, writing the word "pending" in Pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> c. LENGTH OF STAY IN 1b <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>125 Maple St.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> d. STREET ADDRESS <b>125 Maple St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT</b> First Middle Last <b>MILBOURN</b> <b>REVELLE</b>		4. DATE OF DEATH Month Day Year <b>June 3 19 61</b>	
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 28, 1937</b> 9. AGE (in years last birthday) <b>23</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Pleasure Boat Mfg.</b> 11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>R. Milbourn Revelle</b> 14. MOTHER'S MAIDEN NAME <b>Florence Marie Davis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes 1957 (6 Mos.)</b> 16. SOCIAL SECURITY NO. <b>219-34-3964</b> 17. INFORMANT <b>Mrs. Florence Marie Milbourn--</b> Address <b>125 Maple St. Crisfield, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage (brain stem) due to blow on head with baseball.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Struck in forehead by baseball from foul tip</b>	
20c. TIME OF INJURY Month, Day, Year <b>3:00 p.m. June 2 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Recreation area</b> 20f. (City or town) (County) (State) <b>Crisfield Somerset Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>C. G. Rawley</b> EXAMINER'S NAME (Type) <b>C. G. Rawley, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>6/5/61</b> Address (Street, city, town, or county) <b>Crisfield, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 5, 1961</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons</b> ADDRESS <b>Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 9 '61</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Wm. L. Thrash</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07179

7190

(M)

PLACE OF DEATH  
o COUNTY

SOMERSET

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
o STATE o COUNTY

MARYLAND

b. COUNTY

SOMERSET

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CRISFIELD

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

39 CRISFIELD

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

EDW. W. MCCREADY MEMO. HOSP.

d. STREET ADDRESS

1 143 S. FOURTH STREET

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

First CLYDE

Middle R

Last SAMPLE

4. DATE OF DEATH

Month JUNE

Day 7

Year 1961

5. SEX

MALE

6. COLOR OR RACE

NEGRO

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

1-14-1888

9. AGE (In years last birthday) yrs.

75

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN A. SAMPLE

14. MOTHER'S MAIDEN NAME

ANNIE BIGNERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

720-01-9049A

INFORMANT

Address

SALLY A. SAMPLE, CRISFIELD, MARYLAND

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Heart dilatation, heart

INTERVAL BETWEEN ONSET AND DEATH

720-1  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO

Coronary occlusion -

DUE TO

Left Arteriosclerosis -

10 days

years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 19 to 6-7-61, 19, that I last saw the deceased alive on 6-7-61, 19, and that death occurred at 10:35 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

OK Hawley

M.D.

CRISFIELD, MARYLAND

PHYSICIAN'S NAME (Type)

J. G. RAWLEY, M. D.,

CRISFIELD, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

June 11, 1961

22c. NAME OF CEMETERY OR CREMATORY

History

22d. LOCATION (City, town, or county)

CRISFIELD

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Anthony J. Wood 114 S. 4th St. Crisfield, Md.

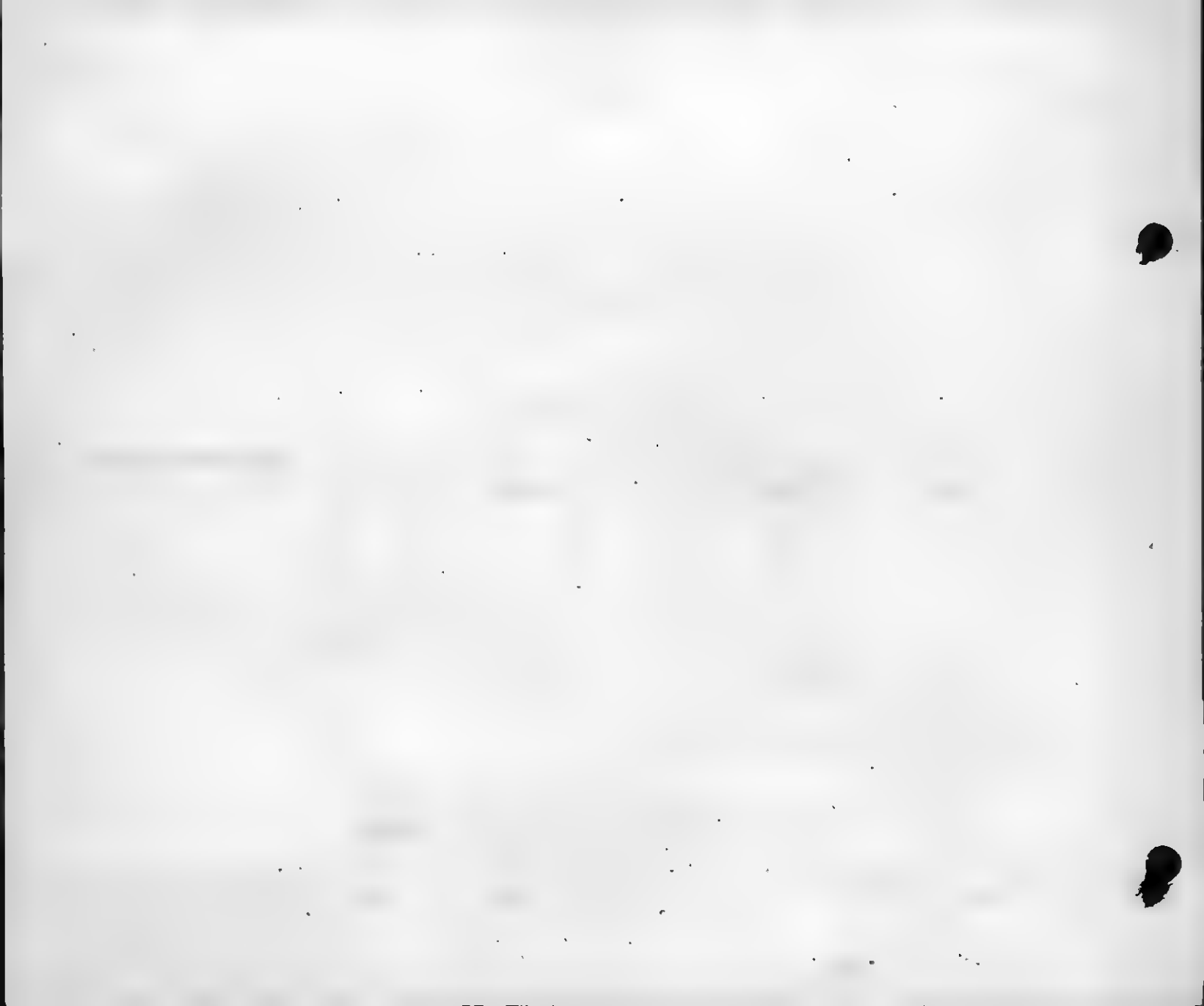
24a. REC'D BY REGISTRAR

DATE JUN 12 '61

24b. REGISTRAR'S SIGNATURE

Arthur L. Hanna

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



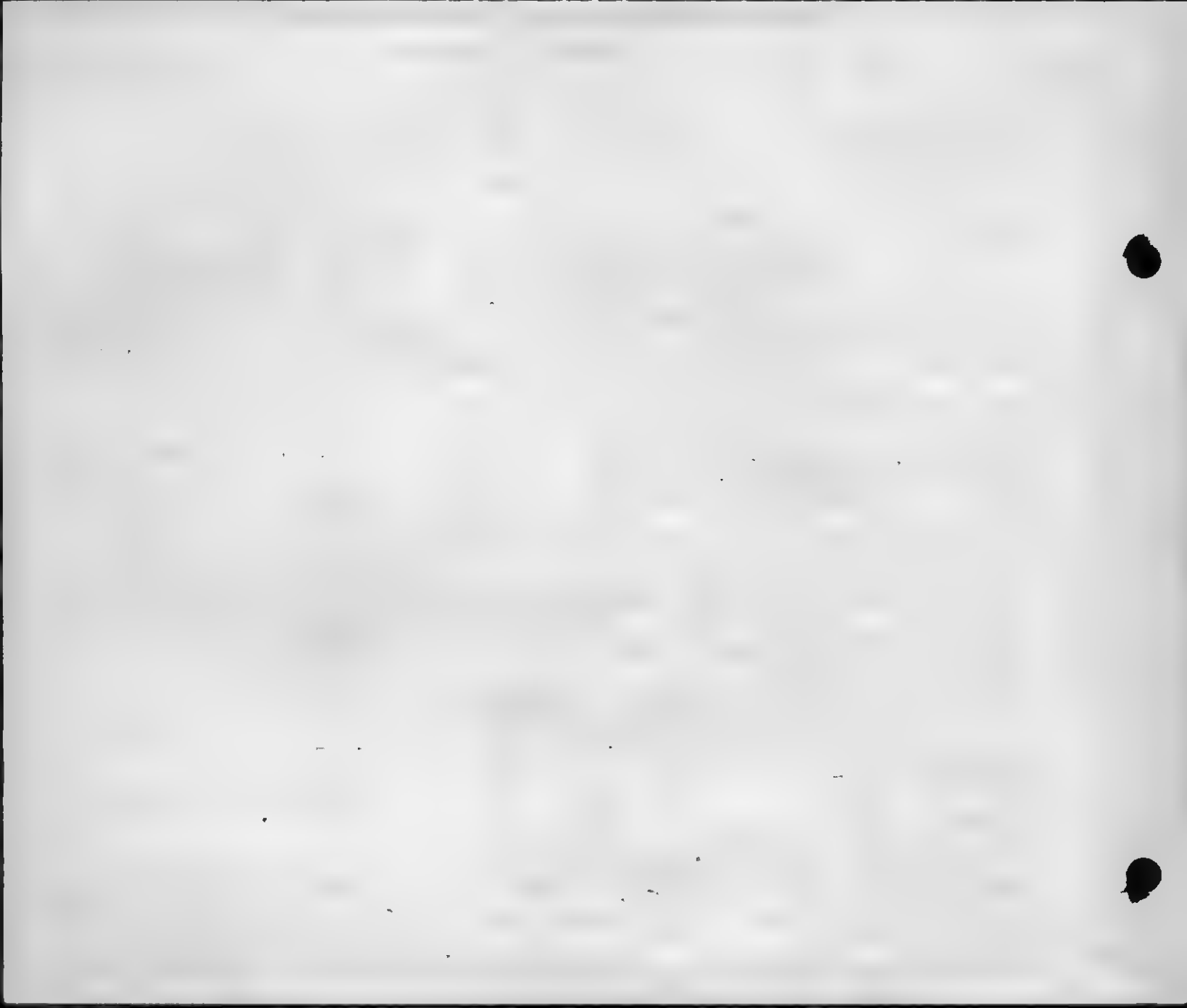
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 07130

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Granville Sanders		4. DATE OF DEATH Month Day Year June 12 19 61	
5. SEX m	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1877
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Sanders		14. MOTHER'S MAIDEN NAME Esther Pritchett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Amanda Sanders, RFD. Princess Anne			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 months years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-2-59, 19, to 6-12-61, 19, that I last saw the deceased alive on 6-12-61, 19, and that death occurred at 10AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Everett C. Sutter		M.D. Dames Quarter, Md. 6-13-61	
PHYSICIAN'S NAME (Type) Everett C. Sutter MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/14/61	
22c. NAME OF CEMETERY OR CREMATORY St Andrews		22d. LOCATION (City, town, or county) (State) Princess Anne Md	
23. FUNERAL DIRECTOR'S SIGNATURE James Sumner		ADDRESS Princess Anne, Md.	
24a. REC'D BY REGISTRAR DATE JUN 22 '61		24b. REGISTRAR'S SIGNATURE William S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

7192

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07181

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. LENGTH OF STAY IN lb <b>Lifetime</b> <b>39</b> <b>Crisfield</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>S. Somerset Ave.</b>				d. STREET ADDRESS <b>1 S. Somerset Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>JAMES</b> Last <b>WARD</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1883</b>	
9. AGE (In years lost birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Ward</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Cullen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW 1</b>				16. SOCIAL SECURITY NO. <b>218-05-8809</b>		17. INFORMANT Address <b>Mrs. Lena Ward, S. Somerset Ave., Crisfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> DUE TO <b>002X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>June 20, 1961</b> , that (I) (we) last saw the deceased alive on <b>6-19</b> 19 <b>61</b> , and that death occurred at <b>2:15</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>C. G. Rawley</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>C. G. Rawley, M. D.</b>				22d. ADDRESS <b>W. Main St., Crisfield, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 22, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 23 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

STATE OF TEXAS

1887

(M)

County of ...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

(1)

...

RECORDED

INDEXED

...

...

...

## CERTIFICATE OF DEATH

Reg. Dist. No. 07182

7193

1. PLACE OF DEATH o. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANCE</u>	c. LENGTH OF STAY IN 1b <u>LIFETIME</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANCE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>WHEATLEY</u> Last <u>WHEATLEY</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR-28-1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>GABRIEL JONES</u>	
14. MOTHER'S MAIDEN NAME <u>TRISCILLA WHITE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MARTIN WHEATLEY</u> Address <u>MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterioneophrosis of kidneys</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH years <u>—</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-26-61</u> , 19 <u>—</u> , to <u>6-5-61</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>6-5-61</u> , 19 <u>—</u> , and that death occurred at <u>8pm</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Dames Quarter, Maryland</u> DATE SIGNED <u>6-5-61</u> ACTUAL SIGNATURE <u>Everett C. Sutter</u> M.D. <u>Everett C. Sutter</u> M.D. PHYSICIAN'S NAME (Type) <u>Everett C. Sutter MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 7-1961</u>	22c. NAME OF CEMETERY OR CREMATOR <u>ROCK CREEK</u>	22d. LOCATION (City, town, or county) (State) <u>Chance MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Webster</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 12 '61</u>	24b. REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

00180

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 19

NAME OF DECEASED: *John J. Smith*

AGE: *45* YEARS

SEX: *Male*

RACE: *White*

DATE OF DEATH: *Jan 15 1918*

PLACE OF DEATH: *Home*

CAUSE OF DEATH: *Heart Disease*

DIAGNOSIS: *Myocardial Infarction*

DATE OF BIRTH: *Jan 15 1873*

PLACE OF BIRTH: *Massachusetts*

EDUCATION: *High School*

OCCUPATION: *Teacher*

RELIGION: *Catholic*

SIGNATURE OF PHYSICIAN: *Dr. J. H. Smith*

SIGNATURE OF REGISTRAR: *John J. Smith*

DATE OF REGISTRATION: *Jan 15 1918*

PLACE OF REGISTRATION: *Boston*

REMARKS: *Deceased died of a heart attack while on duty at school.*